DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**02/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKMONT OF LAS VEGAS	**3185 E. FLAMINGO ROAD, LAS VEGAS, NEVADA ,89121**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 01/26/23, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The facility was licensed for 150 Residential Facility for Group beds for elderly or disabled persons and/or Alzheimer's disease and/or assisted living services and/or chronic illness and/or individuals with intellectual disabilities, 120 Category II and 30 Category II (Alzheimer's) residents. The census at the time of the survey was 121. The sample size was three. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00067308 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of the physical appearance of residents and the interactions between staff and residents and residents and residents. Interviews were conducted with residents, the Interim Executive Director, the Health Services Director, a Lead Caregiver and the Business Office Manager. Record Review of three records, which included the resident of concern. Document Review included facility policies and procedures, the hospital records of the resident of concern and the financial ledger of the resident of concern. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.